PRE-APPLICATION TO MEDICAL STAFF

The purpose of this questionnaire is to verify that your credentials are in good standing with the appropriate licensing board, National Practitioner Data Bank, and other associations before an authorized approval and hiring determination is made.

All mental health clinician applicants (psychologists, social workers) who are applying for the positions listed below, or the equivalent of those positions, must complete this form. **Fax the completed form, along with your CURRENT Curriculum Vitae and other requested documents, to the California Department of Corrections and Rehabilitation (CDCR) Credential Coordinator at (916) 322-3208.** If you have any questions, the agent may be reached by telephone at (916) 327-3336.

TO PREVENT UNNECESSARY DELAYS IN PROCESSING YOUR APPLICATION, PLEASE PRINT LEGIBLY AND PROVIDE ALL REQUESTED INFORMATION.

Application for the Position of: ☐ Psychologist ☐ Senior Psychologist ☐ Chief Psychologist ☐ Social Worker ☐ Supervising Social Worker

Name: Last: _____ First: _____ Middle: _____

Other Names Used: _____ Gender: ☐ Female ☐ Male

Full Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street Address City State Zip Code

Contact Information: _____
e-mail address phone numbers

United States Citizen: ☐ Yes ☐ No. If no, what kind of visa will you hold while you are here?

Type: _____ Sponsor: _____ Expiration Date: _____

If you hold permanent immigrant status in the U.S., please attach a copy of your green card or approval letter.

National Identification number: _____ Country of Issue _____

Professional school(s) (M.A./M.S., Ph.D./Psy.D., etc.):

Name	Degree	Year Graduated

Professional license(s)/certifications/registrations (medical, nurse practitioner, physician assistant):

License Type: _____ Board: ☐ BOP ☐ BBSE

License number: _____ State: _____ License number: _____ State: _____

☐ Unlicensed Hours accrued toward licensing _____

Please send official transcripts from professional schools to: DCHCS – Credentialing Coordination Unit
P.O. Box 942883
Sacramento, CA 94283

Date transcripts ☐ ordered ☐ mailed to DCHCS: _____

BLS Certification: _____ Expiration Date: _____
(Please attach a copy the certificate to this application)

ANY AFFIRMATIVE ANSWER TO QUESTIONS ONE THROUGH 18 REQUIRES ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER, ELABORATING UPON THE RESPONSE AND DESCRIBING THE CIRCUMSTANCES INVOLVED.

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? □ Yes □ No
2. Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily? □ Yes □ No
3. Have you ever been asked to surrender your license? □ Yes □ No □

☐ Additional information is attached for the above section (questions ___, ____, ___)

---

4. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example Medicare, CHAMPUS, or Medicaid)? □ Yes □ No
5. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program? □ Yes □ No

---

6. Have you ever been named as a defendant in any criminal proceedings? □ Yes □ No
7. Has your employment, Medical Staff appointment, or clinical privileges ever been suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily? □ Yes □ No
8. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before the hospital or health facility's Board made a decision? □ Yes □ No
9. Have you ever been the subject of focused individual monitoring at any hospital or health care facility? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ____)

---

10. Have any profession liability claims or suits ever been filed against you or are any presently pending? □ Yes □ No
11. Have any judgments or settlements been made against you in professional liability cases? □ Yes □ No
12. Had your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? □ Yes □ No
13. Has any information pertaining to, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___)

---

14. Are you able to perform all the services required by your agreement with, or the professional bylaws of, the Division of Correctional Health Care Services to which you are applying, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients? □ Yes □ No
15. Does your curriculum vitae show any gaps in training or practice greater than 3 months in duration? □ Yes □ No
16. Have you ever been examined by any specialty board and failed to pass the examination? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___, ___)

FOR QUESTIONS 17 AND 18 PROVIDE ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER WHEN DIRECTED TO DO SO AS A RESULT OF YOUR ANSWER

17. If not currently licensed, have you applied for licensure?
    Do you intend to apply for the relevant licensure exam? ☐ Yes ☐ No.
    If no, please explain why on a separate piece of paper. ☐ Additional information attached.

18. Have you been accepted to take the relevant licensure exam? ☐ Yes ☐ No
    If yes, what dates are/were you scheduled to take the licensure exam? _____

APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this application is true and complete. Any misrepresentation, misstatement, or omission from this pre-application, whether intentional or not, may constitute sufficient cause for rejection of this pre-application resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

_____ _____
Signature of Applicant Date